§ 9788.13 Reimbursement for Reports, Duplicate Reports, Chart Notes

This section governs reimbursement of all reports other than those which are payable under the medical-legal fee schedule, found at Section 9795. The medical-legal fee schedule should only be used for the reimbursement of reports which are requested by a party for the purpose of proving or disproving a contested claim. Reports obtained for the purpose of determining whether to accept or contest a claim are governed by this section. This section covers all treatment reports required by statute or regulation, and consulting reports which are requested by a party.

Separately reimbursable reports identified by the CPT code 99080 (Special Reports) are reimbursed as follows: $39.97 for the first page and $26.00 for each additional page, up to a total of six pages. Reimbursement is limited to six pages except by mutual agreement of the provider and payer. Separately reimbursable reports identified by the California code CA001 are reimbursed at $12.30.

(1) Treatment Reports Not Separately Reimbursable. The following treatment reports are not separately reimbursable as the appropriate fee is included within the underlying Evaluation and Management service for an office visit (CPT codes 99201-99215).

(a) Doctor's First Report of Occupational Illness or Injury (Form 5021) (or other report of primary care provider with similar information);
(b) Initial treatment report and plan;
(c) Treating Physician's Report of Disability Status (DWC Form RU-90) where the physician has not been able to give an opinion regarding the employee's ability to return to the pre-injury occupation;
(d) Report by a secondary physician to the primary treating physician.

(2) Treatment Reports That Are Separately Reimbursable.
The following treatment reports are separately reimbursable. Where an office visit is included, the report charge is payable in addition to the underlying Evaluation and Management service for an office visit (CPT codes 99201-99215).

(a) **Primary Treating Physicians' Progress Reports**, reported in accordance with §9785 of Title 8, California Code of Regulations, using DWC form PR-2 or its narrative equivalent, when (1) the employee's condition undergoes a previously unexpected significant change; (2) there is any significant change in the treatment plan reported in the Doctor's First Report including, but not limited to, an extension of duration or frequency of treatment, a new need for hospitalization or surgery, a new need for referral to or consultation by another physician, a change in methods of treatment or in required physical medicine services, a need for rental or purchase of durable medical equipment or orthotic devices; (3) the employee's condition permits return to modified or regular work, but the employee has not reached permanent and stationary status; (4) the employee's condition requires him or her to leave work or requires a change in work restrictions or modifications; (5) the employer reasonably requests additional appropriate information.

(6) A progress report shall be submitted no later than 45 days from the submission of the last progress report even if no event described in paragraphs (1)-(5), above, has occurred. Progress reports are separately reimbursable even if the change in the patient's condition or treatment warranting a progress report occurs during the surgical global follow-up period. Use code CA001.

(b) **Final Treating Physician's Report of Disability Status (DWC Form RU-90)** where the physician renders an opinion concluding that the employee is released to return to the pre-injury occupation or concluding that the employee's injury is likely to permanently preclude the employee from returning to the pre-injury occupation. Use Code 99080.

(c) **Primary Treating Physician's Final Discharge Report** where the physician determines that no further medical treatment is needed for this injury, the patient has no permanent disability, and the employee is able to return to work with no restrictions or diminished capacity related to this injury. The final discharge report must be submitted using DWC Form PR-2 or its equivalent. Use Code CA001.

(d) **Primary Treating Physician's Permanent and Stationary Report.** The physician's permanent and stationary report issued in accordance with Section 9785 shall be reported using 99080. The physician may also report the appropriate *Current Procedural Terminology 2003's* Evaluation and Management code, if any, and, when appropriate, prolonged service codes 99354-99358.

Modifier '-17' is to be used by the primary treating physician to identify a permanent and stationary evaluation and report. This modifier shall be appended to each of the following codes, as appropriate: Evaluation and Management codes, report code 99080, and prolonged service codes.

(e) **Provider Reports That Are Not Legally Mandated.** When a claims administrator or its authorized agent requests that a provider complete a form that is not legally mandated or submit information in excess of that required pursuant to Section 9785, the provider shall be separately reimbursed using code 99080. Attach modifier '-18' to identify these forms or reports.

(3) Consultation Reports. The following reports are separately reimbursable. Where an examination of the patient is included, the report charge is payable in addition to the underlying Evaluation and Management service for a consultation (CPT codes 99241-99245) or confirmatory consultation (CPT codes 99271-99275) as noted below. Use Code 99080. Where there is no examination of the patient, see "Prolonged Service Codes", below.

(a) A report by a consulting physician, where consultation was requested on one or more medical issues by the treating physician, including a second medical opinion on the necessity or appropriateness of previously recommended medical treatment or a surgical procedure. A confirmatory consultation (CPT codes 99271-99275) may also be charged by the consulting physician.

(b) A report by a consulting physician, where consultation was requested on one or more medical issues by a party, the Administrative Director, or the Workers' Compensation Appeals Board. Reports included under this section are those reports that are admissible and reimbursable in accordance with Labor Code Section 4064(c). An office consultation (CPT codes 99241-99245) may also be charged by the consulting physician.

(c) A report by the treating physician, where medical information other than that required to be reported under the treatment report section above was requested by a party, the Administrative Director, or the Workers' Compensation Appeals Board. An office consultation (CPT codes 99241-99245) may also be charged by the treating physician in this circumstance.

(d) A report by a consulting physician where the claim does not meet the criteria of a "contested claim" as set forth in 8 CCR § 9793(b).

(e) A consultation code may not be billed when care or any part of care has been clearly transferred by the primary treating physician to another physician.

(4) Chart Notes. Requests for chart notes shall be in writing and shall be separately reimbursable at $10.00 for up to the first 15 pages. Pages in excess of 15 shall be reimbursable at $0.25 per page. Chart note requests shall be made only by the claims administrator. Code CA002 is used to bill for chart notes “By Report”, using these guidelines.

(5) Duplicate Reports. A primary treating physician has fulfilled his or her reporting duties by sending one copy of a required report to the claims administrator or to a person designated by the claims administrator to be the recipient of the required report. Requests for duplicate reports related to billings shall be in writing. Duplicate reports shall be separately reimbursable. Where the payer requests an additional copy of the reports, the payer shall reimburse for the duplicate report at $10.00 for up to the first 15 pages. Pages in excess of 15 pages shall be reimbursed at $0.25 per page. Charges for duplicate reports shall be billed using code CA003. Requests for duplicate reports shall be made only by the claims administrator.